# APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

NAME OF INSURANCE COMPANY

| DATE | OUR POLICY HOLDER | DATE OF ACCIDENT | FILE NUMBER |
|---|---|---|---|
| | | | |

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

| YOUR NAME | PHONE NO. | HOME | BUSINESS |
|---|---|---|---|
| | | | |

| YOUR ADDRESS (NO, STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH | SOCIAL SECURITY NO. |
|---|---|---|
| | | |

| PERMANENT ADDRESS, IF DIFFERENT | HOW LONG HAVE YOU LIVED IN FLORIDA? |
|---|---|
| | |

| DATE AND TIME OF ACCIDENT | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE) |
|---|---|
| | |

BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

| DESCRIBE MOTOR VEHICLE YOU OWN - | DESCRIBE MOTOR VEHICLE OWNED BY ANY MEMBER OF YOUR FAMILY- |
|---|---|
| | |

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

**SIGNATURE:** **DATE:**

DESCRIBE YOUR INJURY

| WERE YOU TREATED BY A DOCTOR? | | DOCTOR'S NAME AND ADDRESS |
|---|---|---|
| | | |
| IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN PATIENT ____ OUT PATIENT _____ | | HOSPITAL'S NAME AND ADDRESS |
| | | |

| AMOUNT OF MEDICAL BILLS TO DATE | WILL YOU HAVE MORE MEDICAL EXPENSE? | AT THE TIME OF YOUR ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? |
|---|---|---|
| | | |

| DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? | IF YES, AMOUNT OF LOSS TO DATE | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? |
|---|---|---|
| | | |

| IF YOU LOST WAGES: | DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK |
|---|---|---|
| | | |

| HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKMEN'S COMPENSATION OR EMPLOYMENT LAW? | IF YES, AMOUNT PER WEEK PER MONTH |
|---|---|
| | |

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH

| EMPLOYER AND ADDRESS | YOUR OCCUPATION | FROM | TO |
|---|---|---|---|
| | | | |
| EMPLOYER AND ADDRESS | YOUR OCCUPATION | FROM | TO |
| | | | |
| EMPLOYER AND ADDRESS | YOUR OCCUPATION | FROM | TO |
| | | | |

| AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? | IF YES, EXPLAIN ON REVERSE SIDE |
|---|---|
| SIGNATURE: DATE: | |

**IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS COMPLETE AND SIGN THIS APPLICATION**
**2. SIGN AND ATTACH AUTHORIZATION(S)**
**3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE**

**OFFICE OF INSURANCE REGULATION**
***Bureau of Property & Casualty Forms and Rates***

## Standard Disclosure and Acknowledgement Form
## Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

| Name *(PRINT or TYPE)* | Signature | Date |
|---|---|---|

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

| Name *(PRINT or TYPE)* | Signature | Date |
|---|---|---|

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.